Supreme Court, U.S.
FILED

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No.

In the

Supreme Court of the United States

LINDA MANIATTY,

Petitioner,

– against –

UNUMPROVIDENT CORPORATION, FIRST UNUM LIFE INSURANCE COMPANY, SBC GROUP LONG TERM DISABILITY PLAN, UBS AG LONG TERM DISABILITY PLAN (AND SUCCESSORS IN INTEREST),

Respondents.

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Where a disability insurance policy or plan does not define "objective evidence" and provides disability benefits where the insured, because of injury or illness, is unable to perform the duties of her regular occupation, may the insurer require disability be proven by "objective evidence"?

PARTIES TO THE PROCEEDING

Petitioner is Linda Maniatty.

Respondents are UNUMProvident Corporation, First UNUM Life Insurance Company, SBC Group Long Term Disability Plan, UBS AG Long Term Disability Plan (and successors in interest).

STATEMENT PURSUANT TO RULE 29.6

Respondent First UNUM Life Insurance Company is owned by UNUM Holding Company. UNUMProvident Corporation owns UNUM Holding Company. The stock of UNUMProvident Corporation is publicly held.

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BASIS FOR JURISDICTION

Petitioner seeks a writ of certiorari to review the judgment of the United States Court of Appeals for the Second Circuit in this case. By Summary Order of May 15, 2003 (62 Fed.Appx. 413, 2003 WL 21105390) (Appendix A), the Second Circuit affirmed the decision of the district court, 218 F.Supp.2d 500 (S.D.N.Y. 2002) (Appendix B). Petitioner invokes this Court's jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISION INVOLVED

Petitioner sought review by the district court, pursuant to 29 U.S.C. § 1132(a)(1)(B) under the Employee Retirement Income and Security Act ["ERISA"], of a final administrative determination by defendants, which terminated her long-term disability benefits. The jurisdiction of the district court was thus based upon federal question, 28 U.S.C. § 1331. Appellate jurisdiction in the court of appeals was under 28 U.S.C. § 1291.

STATEMENT OF THE CASE

A. *Administrative Claim*

Petitioner is covered by an employer-sponsored, group long-term disability policy (funded by First UNUM Life Insurance Company), which is an ERISA plan, and it provided her with $5,000 per month until UNUMProvident Corporation (the claims administrator under the Plan) terminated benefits effective October 18, 1999. Following petitioner's request for administrative review of the adverse determination, UNUMProvident's affirmation on July 14, 2000 became the final administrative determination. It stated that petitioner's doctor "does not indicate or provide any objective evidence of a disorder that would provide medical restrictions and limitations that would continue to preclude Ms. Maniatty from performing the material duties of her occupation beyond October 17, 1999." It also stated:

> Since July 1999, the insured has been complaining of fatigue in addition to back pain, and has now been diagnosed wit [sic] chronic fatigue syndrome and fibromyalgia by several physicians who saw the insured only once at the request of her lawyer.

Nothing else was mentioned in the letter concerning these illnesses. Having exhausted administrative remedies, petitioner sought judicial review.

B. *Facts Presented*

In the district court, petitioner's principal brief initially addressed her orthopedic injury by noting that following her lumbar spinal surgery in September 1997, her pain continued, her neurosurgeon ordered an MRI in May 1998, and it revealed:

> Status post left-sided discectomy at L5-S1 with small residual disc protrusion and surrounding scar tissue. Minimal displacement proteriorly of the left S1 root.

That was the same nerve root that was involved in her surgery.

In June 1998, after the MRI, Dr. Collias saw petitioner in consultation. While suggesting that decompression of the S1 root during the September 1997 discectomy was adequate, his impression was that there was "a double structure in the left S1 nerve root canal . . . to suggest there might be a retained fragment there although I am not entirely certain." Later that month, Dr. Cammisa (another consultation) reviewed the May 1998 MRI films and his impression was that they revealed a "Recurrent herniated nucleus pulposis, left L5-S1, with degenerative disease." More than a year later, following months of physical therapy, petitioner saw yet another spinal surgeon, Dr. O'Leary, in August 1999, who suggested more rehabilitation, and if no improvement in six months, then "she might need a spinal fusion at the L5/S1 segment." Dr. Simotas, the physiatrist to whom Dr. O'Leary

had referred her, indicated in November 1999 that he saw no evidence of recurrent disc herniation or nerve root compression on the May 1998 MRI, but possibly a fragment in the left S1 foramen. Dr. Lavyne, the treating neurosurgeon, writes on June 3, 1998 that the May 1998 MRI shows petitioner suffered a:

> small recurrent disc herniation which is accounting for her slow recovery. She would like to be able to return to work as soon as possible, but her condition prevents her from doing so. . . .

He also found "residual weakness in the left lower extremity" on her last neurological examination.

Dr. Bachrach (an osteopath) examined petitioner and treated her with physical therapy and injections into her sacroiliac (with Marcaine) between October 1998 and January 1999. His Physical Capacities Evaluation also indicated that plaintiff could only sit one or two hours in an eight-hour day and was not even able to work part-time. During this period of time, from August of 1998 through December 1998, petitioner had undergone physical therapy. An assessment on August 10, 1998 indicated that she had severe pain with sitting, and radiating pain in the lower left extremity with standing or walking. Notably, the physical therapist (Ms. Erni) found that petitioner's endurance was diminished and her fatigue markedly increased, to the point where she was unable to sit for prolonged periods or perform activities of daily living.

On February 2, 1999, Dr. Lavyne completed a form for UNUM indicating restrictions and limitations primarily as the inability to sit comfortably, remained hopeful she might eventually return to part-time work, but in the meantime estimated her ability to sit, stand, and walk as only one hour each in an eight-hour workday. On July 15, 1999, Dr. Lavyne opined that while her neurologic examination had returned to normal, his impression was that plaintiff's "chronic lower

back pain . . . is a residual of the nerve injury and not likely to improve further." He also remarked that she was complaining of fatigue and suggested it might be a symptom of depression, for which he referred her back to her internist. In September 1999, Dr. Lavyne responded to UNUM's inquiry as to his basis for concluding that the lower back pain was "a residual of the nerve injury and not likely to improve," saying it was the "clinical examination and my experience caring for neurologically injured." On November 22, 1999, he wrote to UNUM's Dr. Alexander:

> In my estimation, this chronic lower back pain is disabling her. Although her neurologic examination is normal, I have not performed a detailed sensory examination of her lower sacral dermatomes and perhaps there are objective bedside signs of sensory disorder. Regardless of the presence or absence of neurologic deficits, she is in pain and unable to return to work.

Dr. Balensweig examined Ms. Maniatty on January 17, 2000 and provided a comprehensive orthopedic report. He notes her complaints of difficulty with sitting and standing (both about ten minutes) and how she spends most of every day and night reclining or sleeping. Clinical examination was remarkable for L5 sensory loss on the left and reflex deficits in the left knee jerk, left posterior tibial, left gluteal, and left hamstring. There was also tenderness at the left sciatic notch and coccyx. Dr. Balensweig reviews many of the reports already discussed above and then his impression, in pertinent part, was that:

> This patient has a recurrent disc herniation in the left foramen at L5-S1, scar tissue and positive neurological findings. I would recommend she be operated upon by Dr. Patrick O'Leary and have a fusion at L5-S1 plus a laminectomy again with removal of disc material in the foramen and opening up of the foramen.

A Physical Capacities Evaluation completed by Dr. Balensweig shows that petitioner, during an eight-hour day, can sit less than two hours, stand less than one hour, and needs to recline almost continuously (which makes it clear that, in his opinion, plaintiff was incapable of performing even a part-time job).

Petitioner's principal brief in the district court then addressed her Chronic Fatigue Syndrome ["CFS"] and Fibromyalgia ["FM"]. Dr. Hart (primary care internist) reports on March 27, 1998 that plaintiff is "[e]xhausted" and then repeats that in a letter dated April 8, 1999.

Eveline Erni, P.T. reported to Dr. Lavyne on August 10, 1998 that plaintiff "has decreased endurance and extreme fatigue w/minor activities." On November 30, 1998 physical therapy notes state: "greatly bothered by fatigue." On December 10, 1998, it is noted that her sitting time has increased to thirty minutes, an improvement from two months before.

Dr. Globus was seen in consultation on June 21, 1999 and a lab test ruled out Lyme disease. On a questionnaire form petitioner responded to the question, "Do you tire very easily?" by answering, "only since my operation. . . ." His history mentions that she can't sit for more than thirty minutes and is "Exhausted if out for more than 2 hours — If out for more than 2 hours . . . then several days to recover."

In an update of February 9, 2000, Dr. Hart writes that "shortly after her surgery, she developed overwhelming fatigue, occasional sweats, nausea and light-headedness." Dr. Hart completed an Estimated Functional Abilities form for UNUM dated July 14, 1999, which indicates an inability to perform even sedentary activity.[1]

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[1] There was a highly prejudicial blunder by the district court regarding this form. The Memorandum Order states: "and a third doctor, Dr. Hart, reported sedentary capacity. AR 295-96". If you look at AR 295-96, it's a UNUM nurse's review, which says: "EFA [Estimated Functional Abilities]

Dr. Levine examined on December 3, 1999. The history recorded was consistent with that of Dr. Hart and Dr. Globus in the complaint of post-surgical pain and exhaustion. Dr. Levine then identified presenting symptoms from petitioner:

> extreme exhaustion even after minimal exertion; significant muscle pain in the shoulders, neck, and lower back; and sleep disturbances. She is unable to sit for more than about 1/2 an hour no more than a few times a day; she cannot stand for more than 10 minutes at a time no more than 3 times a day; she cannot read or write for long periods of time; and she does not feel rested when she awakens.

Dr. Levine's clinical examination was positive for:

> small lymph nodes in the anterior cervical area . . . slightly diminished motor strength in all extremities; and she had bilateral trigger points in her neck, shoulders, elbows, and knees. Her labwork indicated prior exposure to Human Herpes Virus 6, which has been implicated as a causative agent in CFS/FM....

Dr. Levine diagnosed CFS and FM and then noted resultant functional limitations which left petitioner totally disabled.

Lastly, there is a consultation with Dr. Podell dated April 5, 2000. After a detailed review of petitioner's history and medical records, his clinical examination pertinently revealed:

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form from Dr. Hart . . . MD of the opinion clmnt [sic] has sedentary capacity." But that's not what Dr. Hart wrote at all. The form Dr. Hart completed shows that petitioner is unable to engage in "light", "medium", or "heavy" activity, and can only engage in "sedentary" activity for a half hour in an eight-hour day. Thus the misleading nurse's note, misconstruing the form completed by Dr. Hart, resulted in the district court's misbegotten conclusion that petitioner's own doctor admitted she could perform a sedentary occupation. For the district court to rely upon UNUM's nurse's note to reflect what petitioner's treating physician had said, without bothering to confirm it, was both arbitrary and clearly erroneous.

> increased lymph glands on the left and right lateral neck. She had a 3+ post-nasal drip and a 1+ purple crescent of the posterior pharynx. She has a fullness and tenderness in the right and left supraclavicular areas. All 14 of the diagnostic fibromyalgia tender points tested positive.

Dr. Podell found that petitioner meets the criteria for CFS established by the Centers for Disease Control ["CDC"], which he cites and explains.

Dr. Levine's clinical findings were confirmed by Dr. Podell. Both found cervical lymph nodes and bilateral trigger points on examination and both reported similar symptoms. Dr. Podell likewise confirms total disability, not just for petitioner's own occupation, but also for "any job full or part time."

C. *The District Court's Memorandum Order (Appendix B)*

The Memorandum Order indicated (at APP-7) that UNUM had concluded that petitioner's complaints regarding her low back pain were "subjective in nature, without *objective evidence* for continued lumbar dysfunction" (emphasis ours) and that she was no longer disabled. Specifically, UNUM said Dr. Lavyne was unable to "point to any *objective evidence* supporting plaintiff's pain complaints" (emphasis ours).

The Memorandum Order then agreed with UNUM that petitioner's raising the additional illnesses of CFS and FM for the first time during her administrative appeal was reason for skepticism (apparently oblivious to the fact that she had not been diagnosed with these illnesses until *after* her benefits had been terminated). It further noted that a UNUM review physician reviewed reports concerning CFS and FM from doctors Levine and Podell and concluded that their findings were based upon petitioner's subjective complaints. The Memorandum Order then dismissed petitioner's argument that the Plan itself does not state that *objective evidence* is required to establish disability by inferentially reasoning

that requiring proof of disability "connotes objectivity" (at APP-9) and concludes (at APP-9): "Thus, given the virtual absence of any *material objective evidence* to support plaintiff's claim, it can hardly be said that the administrator acted in an arbitrary and capricious matter [sic] in rejecting plaintiff's claim" (emphasis ours).

As if to bolster its opinion, the Memorandum and Order gratuitously claims (at APP-9) that it would have reached the same conclusion under a *de novo* standard because the only *material objective evidence* was the post surgical MRI, which did not conclusively establish that petitioner qualified for long-term disability.

D. *Summary Order By The United States Court Of Appeals (Appendix A)*

The Second Circuit did not bother to discuss any of petitioner's arguments below in summarily affirming the decision of the district court. Instead it curtly concluded that the district court did not "abuse its discretion in finding that plaintiff is unable to demonstrate that she is unable to perform each of the material duties of her regular occupation because of injury or sickness."

REASON FOR GRANTING THE WRIT

A. *Introduction*

Supreme Court Rule 10(a) indicates that it is within this Court's discretion to grant a writ of certiorari where a United States Court of Appeals:

> has decided an important federal question in a way that . . . has so far departed from the accepted and usual course of judicial proceedings, or sanctioned such a departure by a lower court as to call for an exercise of this Court's supervisory power . . .

In support of its decision that UNUM could require *material objective evidence* of disability, even though *material objective evidence* is neither defined nor required by the Plan, defendants and the district court cited only one, unreported case, *Baily v. Provident Life & Accident Ins. Co.*, 3: 99-CV-394/LAC (D.C. Fla. June 13, 2000)! The case law from various circuit courts of appeals, *infra*, is to the contrary and even the Eleventh Circuit unequivocally holds: "A claims administrator's decision is arbitrary and capricious where new requirements for coverage are added to those enumerated in the plan. *Florence Nightingale Nursing Service, Inc. v. Blue Cross/Blue Shield of Alabama*, 41 F.3d 1476, 1484 (11th Cir. 1995), *cert den,* 115 S.Ct. 2002 (1995).

Moreover, where *material objective evidence* is neither defined nor required by a Plan, superimposing that requirement for various illnesses, e.g. CFS and FM, is draconian and will unfairly and adversely impact thousands of ERISA disability claimants.

B. *Contractual*

In petitioner's principal brief in the Court of Appeals, she argued (Principal Brief at 25):

> As the Policy is a contract, defendants may not simply add new terms. *Mitchell v. Eastman Kodak Co.*, 113 F.3d 433 (3d Cir. 1997); *Cohen v. Standard Ins. Co.*, 155 F.Supp.2d 346 (E.D. Pa. 2001); *Saliamonis v. CNA*, 127 F.Supp.2d 997, 1000 (N.D. Ill. 2001); *Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 330 (7th Cir. 2000). . . [2]

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[2] Insurers are free to define "objective evidence" and have done so in other LTD plans. *See Friedrich v. Intel Corp.*, 181 F.3d 1105 (9th Cir. 1999). Some other cases holding ERISA claims administrators may not require "objective evidence" when it is not required by the plan language are *Durr v. Metropolitan Life Ins. Co.*, 15 F.Supp.2d 205, 213 (D.Conn. 1998); *Pelchat v. UNUM Life Ins. Co. of America*, No. 3:02CV7282,

> Instead of viewing defendants' requirement for "objective evidence" as being in derogation of the policy, the District Court superimposed its own definition of "objective evidence." It inferentially reasoned that because the policy requires proof of loss (*see* A-111), "the very concept of proof connotes objectivity" (A-1162). Of course, the "proof of loss" required by the Policy merely implies required documentation (i.e. medical records) and has no provision for dismissing subjective complaints.[3]

C. *The District Court Unreasonably Dismissed Petitioner's Subjective Complaints And Ignored Jurisprudence Acknowledging The Viability Of Claims Based Upon Chronic Fatigue Syndrome and Fibromyalgia*

Petitioner then cited *Connors v. Connecticut Gen'l Life Ins. Co.*, 272 F.3d 127, 136-37 (2d Cir. 2001) for the Second Circuit's numerous cases holding that subjective complaints may not be dismissed as legally insufficient evidence of disability. With respect to petitioner's CFS and FM (as illnesses in addition to her lumbar spine injury which the district court found "subjective"), it was noted (Principal Brief at 27) that:

2003 WL 21105075 (N.D.Ohio May 12, 2003) (*citing Mitchell* and *Florence Nightingale*) and *Saffle v. Sierra Pacific Power Co.*, 85 F.3d 455, 460 (9th Cir. 1996).

[3] *Cf. Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 251 (2d Cir. 1999) (insurer's claim, that discretionary authority was conferred by language saying they'll pay benefits if insured, "submits satisfactory proof of Total Disability to us," was rejected by this Court as unclear:

> Since language can be readily drafted and included in policies . . . courts should require clear language and decline to search in semantic swamps for arguable grants of discretion.

Similarly, the district court may not infer that requiring proof of disability "connotes" a requirement for *material objective evidence.*

a substantial jurisprudence recognizes CFS[4] as a basis for disability benefits, in both ERISA and Social Security claims, *e.g. Sansavera v. E.I. DuPont de Nemours & Co.*, 859 F.Supp. 106, 113 (S.D.N.Y. 1994); *Locher v. UNUM Life Ins. Co. of America*, 126 F.Supp.2d 769, 775 (S.D.N.Y. 2001); *Hilton v. Apfel*, 56 Soc.Sec.Rep.Serv. 156, 1998 WL 241616 (S.D.N.Y. 1998); *Lunan v. Apfel*, 67 Soc.Sec.Rep.Serv. 114, 2000 WL 287988 (N.D.N.Y); *Rose v. Shalala*, 34 F.3d 13 (1st Cir. 1994); *Hallgring v. Callahan*, 975 F.Supp. 84 (D.Mass. 1997); *Cohen v. Secretary*, 964 F.2d 524 (6th Cir. 1992); *Mitchell v. Eastman Kodak Co.*, 910 F.Supp. 1044 (M.D.Pa. 1995) *aff'd* 113 F.3d 433 (3d Cir. 1997); *Opgenorth v. Shalala*, 897 F.Supp. 1199 (E.D.Wis. 1995); *Friedrich v. Intel Corp.*, 181 F.3d 1105 (9th Cir. 1999); *Reddick v. Chater*, 157 F.3d 715 (9th Cir. 1998); *Sisco v. Dept. of HHS*, 10 F.3d 739 (10th Cir. 1993); *Clausen v. Standard Ins. Co.*, 961 F.Supp. 1446 (D.Col. 1997). In doing so, the cases recognize that there is no "dipstick test" for CFS, *Sisco*, 10 F.3d at 743-44, that it is a diagnosis of exclusion, *Clausen*, 961 F.Supp. at 1456, and one that is arrived at by scientific method (including clinical examination, laboratory and diagnostic tests), *Sansavera*, 859 F.Supp. at 113.

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[4] The most widely accepted definition of CFS was published by an international group of doctors sponsored by the Centers for Disease Control: Fukuda, K. "The Chronic Fatigue Syndrome: A Comprehensive Approach to its Definition and Study," *Annals of Internal Medicine*, 1994: 121:953-959. Dr. Podell's report provided the CDC's definition for CFS, which indicates that the symptoms must persist for at least six months (to qualify for the diagnosis). While the cause of CFS remains unknown, neither the Policy nor the Plan requires proof of causation. Scientists have reason to believe that CFS may be viral, that it affects the brain, and have noted various neurological and immune system abnormalities. Komaroff, A.L. "The Physical Basis of CFS," *CFS Research Review* (CFIDS Assoc. of America) vol. 1, issue 2 (Spring 2000).

Petitioner also noted (Principal Brief at 30) that courts:

> have also recognized that FM is a diagnosable and recognized sickness that can cause disability, *see e.g.*, *Russell v. UNUM Life Ins. Co. of America*, 40 F.Supp.2d 747 (D.S.C. 1999); *Monroe v. Pacific Telesis Group Comprehensive Disability Benefits Plan*, 971 F.Supp. 1310 (C.D.Cal. 1997); *Weiler v. Shalala*, 922 F.Supp. 689 (D.Mass. 1996); *DeCastris v. State Employees Retirement System Of Illinois*, 679 N.E.2d 825 (Ill. 1997); *Sarchet v. Chater*, 78 F.3d 305 (7th Cir. 1996).[5]

D. *The District Court's Misunderstanding of CFS And Its Scientific Basis As Applied To Petitioner's Claim And The District Court's Erroneous Limitation Of "Objective Material Evidence" To The Post-Surgical MRI (Which Was Misconstrued)*

Petitioner also addressed the district court's skepticism relating to CFS and FM (Principal Brief at 28):

> Because CFS is a diagnosis of exclusion, and one that may not be made until after the individual has been symptomatic for six months, it is common for those afflicted to be misdiagnosed at onset of the illness, and to see several physicians (to rule out other conditions which may be expected to cause severe and chronic fatigue) before finding out what's wrong with them. *See Mitchell*, 113 F.3d at 441. Thus, the District Court's adoption of UNUM's skepticism of plaintiff's late diagnosis of CFS and FM suggests ignorance regarding the diagnostic criteria for CFS.[6]

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[5] The diagnostic criteria for FM may be found in Wolfe, F., "The American College of Rheumatology 1990 Criteria For the Classification of Fibromyalgia," 33 *Arthritis and Rheumatism* 160-72 (Feb. 1990).

[6] The District Court also suggested skepticism of plaintiff's claim regarding CFS and FM was warranted, since "she claimed that she had been suffering from both for years. AR 80" (A-1163-64). However, "AR

Lastly, petitioner's reply brief also focused on respondents' mischaracterizations of her injuries and illnesses as merely "subjective complaints" (Reply Brief at 9-11). Aside from the post-surgical MRI of May 1998, which revealed pathology at the same level as her September 1997 surgery (*Id.*):

> Dr. Collias saw her in June 1998 and his review of the films suggested a possible "retained fragment" at S1 (A-226). Dr. Cammisa's impression of the films (also in June 1998) was of a "Recurrent herniated nucleous pulposis, left L5-S1, with degenerative disease" (A-223). In August 1999, Dr. O'Leary (A-185) suggested rehabilitation and, if no improvement after six months then "she might need a spinal fusion at the L5/S1 segment". In November 1999, Dr. Simotas (A-184) also thought it was possible she might have a disc fragment in the left S1 foramen. Dr. Balensweig (A-163-75) also felt Maniatty had "a recurrent disc herniation in the left foramen at L5-S1" and, although he compliments Dr. Lavyne as a surgeon, he recommends further spinal surgery with Dr. O'Leary. Even UNUMProvident admitted that (A-254, Opposition at 16): "there is objective evidence of degenerative disk disease of the lower spine demonstrated by a small disk protrusion at L5-S1 on MRI and a history of lumbar surgery 9/97. This would result in some reasonable restrictions and limitations."

Thus the District Court's claim that there is a "virtual absence of any material objective evidence to support plaintiff's claim" (A-1163) is simply false. The bar, however, was then raised by UNUMProvident, in its persistent badgering of

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80" (A-127) is plaintiff's appeal letter and offers no such "claim." Moreover, by all accounts within the record regarding plaintiff's CFS and FM (e.g., A-129 (Dr. Podell), A-135 (Dr. Levine), and A-252 (UNUM's review), those illnesses were diagnosed two years after her September 1997 spinal surgery, and were not pre-existing conditions.

Dr. Lavyne, to demonstrable neurological findings on clinical examination. Dr. Lavyne admitted that she did not have reflex deficits and that he didn't test for sensory deficits (A-176), but did find "residual weakness in the left lower extremity" (A-183), and stated (A-176): "Regardless of the presence or absence of neurologic deficits, she is in pain and unable to return to work." Maniatty's physical therapist also found "[s]igns and symptoms consistent with S/P micro-diskectomy" (A-188), including radiating pain and weakness in the left lower extremity, which caused severe pain with sitting.

Petitioner then noted (Reply Brief at 11-12):

> CFS is recognized by the Centers for Disease Control ["CDC"] as a sickness (Brief at fn. 19) and by the case law as a sickness which may result in disability (Brief at 27). FM is likewise recognized by the American College of Rheumatology as a sickness (Brief at fn. 23) and by the case law as a sickness which may result in disability (Brief at 30).

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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